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Public Health

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TO: Each Supervisor

FROM: Jonathan E. Fielding, M.D., M.P.H.
Director and Health Officer

SUBJECT: **HEALTH CARE REFORM**

We have prepared the attached report that provides the public health perspective on health care reform. The report includes principles for analyzing reform proposals and assesses the likely impact of health care reform on the broad population of Los Angeles County. We intend for this report to serve as a useful companion piece to the critically important analysis of the impact on our County safety net system prepared by your office and Department of Health Services. My staff has been working with DHS staff to ensure that we have a coordinated response to health reform. In addition, David Janssen has reviewed this report and approved my forwarding it to you.

I believe that both reports taken together will help the Board in its consideration of alternatives for health reform.

If you have any questions or need additional information, please let me know.

JEF:wks

Attachment

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THE PUBLIC HEALTH PERSPECTIVE ON HEALTH CARE REFORM

Prepared by:
Los Angeles County Department of Public Health
March 30, 2007

This report provides the public health perspective on health care reform, includes principles for analyzing reform proposals and assesses the likely impact of health care reform on the broad population of Los Angeles County. This report is intended to serve as a tool for evaluating California health care reform proposals and augment the County's overall analysis of health care reform.

The following are recommended public health principles for analyzing reform proposals. Also included are a matrix that applies the principles to the major proposals under discussion, and a summary of these proposals.

Public Health Principles

Create Better Health Care by Design

1) Health care reform should maximize the potential to achieve universal coverage.

For more than two decades, large segments of the California population have lack health insurance coverage. According the most recent statewide data collected by the UCLA Center for Health Policy Research in 2005, twenty percent or roughly 6.5 million Californians are uninsured. Lack of health insurance results it delayed and fragmented care for many persons, inappropriate use of health care resources such as emergency rooms for routine conditions, and uneven economic burdens certain placed on certain providers (e.g., safety net hospitals and community clinics) and payers (e.g., government and large businesses)

As long as some groups have no coverage, pressure is placed on the health care system. Results such as cost shifting or closing emergency rooms affect all users of health services. Universal coverage is a necessary element required to fix the broken health care system.

However, should there be no agreement on a universal approach, incremental approaches should be considered. Programs that have incrementally expanded coverage such as Medicare, Medi-Cal, Healthy Families, and the local Healthy Kids program have been successful. We need to build on the current momentum for health care reform, without setting universality as a precondition for immediate system improvements.

2) Reform should promote prevention and healthy behavior.

Preventable causes of death account for nearly 50% of mortality, and health care reform should target the key determinants of health. While health coverage can increase access to medical

care and improve health outcomes, the major determinants of our leading causes of mortality (heart disease, cerebrovascular disease, diabetes mellitus, and unintentional injuries) are preventable health behaviors (e.g. tobacco use, poor diet, physical inactivity, and motor vehicle and firearm misuse). Incentives that promote the use of preventive services and healthy behavior should be included in any major reform plan. For example, reform plans should provide funding for health promotion at the state and county level.

3) Reform should encourage use of primary care and management of chronic conditions.

Studies show that individuals receive better health care and are more likely to access needed medical treatment and preventive care when they have a "medical home" or routine place they can go to for care. The incentives in our current health care system are often weighted towards acute care and use of medical procedures and technologies rather than preventive care and chronic disease management. Higher acuity care such as inpatient care and medical procedures are reimbursed well, whereas ambulatory care is often reimbursed at a low rate. Activities such as health counseling or evaluation or management of care plans, which are major components of preventive care and evidence-based disease management practice, are often not reimbursed at all. Provider reimbursement, as well as patients' co-pays and deductibles, should be structured to encourage use of preventive and disease management services. In addition, a seamless health care system should promote the concept of a "medical home" or usual source of care.

4) Reform should provide affordable, comprehensive benefits, including prescription drugs, dental, vision, mental health services, and alcohol/drug treatment.

Each individual has a wide range of health care needs beyond medical care, and which may include vision, dental, mental health, alcohol/drug treatment, and prescription drugs. Often, health insurance plans result in high out-of-pocket costs for beneficiaries. An individual with no prescription drug coverage or coverage with a high co-pay, may be unable to afford prescriptions given by their physician, leading to a progression of the problems that brought the individual to seek medical care.

In addition, a reformed health care system should include treatment benefits parity for mental health and substance abuse, which means that coverage not only offers treatment benefits for mental illness and substance abuse disorders but also does not impose treatment limitations or financial requirements on the coverage for mental illnesses and substance abuse disorders if similar requirements are not imposed on coverage of medical and surgical benefits in comparable settings.

5) Insurance carriers must offer affordable, comprehensive products to individuals with pre-existing medical conditions, particularly those purchasing individual policies in the private market.

Studies suggest that the high costs of health care services and health insurance coverage leads many individuals and families to accumulate significant debt and/or to deplete their savings. One reason for this is that the market-based nature of health insurance is geared towards those

without serious health problems, leaving those with health problems with unaffordable options. For example, an individual who does not have employer-sponsored coverage yet has a medical condition is often left with the options of paying an extremely high price for health insurance or being uninsured.

Health care reform must include a mechanism to widen the risk pool for insurers, so they are able to offer an affordable, comprehensive product to high-risk individuals. An individual mandate is one possible mechanism, since it places the largest possible population in the risk pool. Another possible mechanism is to require that private insurers offer an affordable plan with a basic defined set of benefits. The absence of state regulations to assure affordability generally results in high costs and restricted benefits that may not meet essential health care needs of the high-risk population.

6) Reform should simplify the process of enrolling in and retaining coverage and utilizing benefits.

The current health care system can be difficult to navigate for families, particularly those of limited means. Often different family members are eligible for different programs, with different benefits, eligibility requirements, application processes, provider networks, and renewal dates. This confusion can deter both plan enrollment and utilization of care. Reforming Medi-Cal and Healthy Families to allow all family members to enroll in the same program would be a substantial improvement over the current system where eligibility varies by age, income and familial relationships. However, system simplification should not disadvantage populations currently receiving comprehensive benefits. For example, individuals receiving no-cost, full-scope Medi-Cal should not be switched to programs that require premiums and co-pays in the name of simplification.

In addition, the enrollment and renewal processes should be as simple as possible, as many studies and our local experience indicate that many individuals eligible for coverage do not enroll. For example, states that have implemented the federal Deficit Reduction Act (DRA), which requires citizens applying for Medicaid to show proof of citizenship and identity, have experienced declines in Medicaid enrollment that they have attributed to this new requirement. These requirements lead to additional burdens on local safety net systems.

Address the Fiscal Challenges

7) Reform must include measures to contain health care costs.

Among the problems inherent in the health care system is the extremely high cost of care. In 2004, 15% of the U.S. gross domestic product (GDP) was spent on health care. Both the percentage of GDP and the absolute cost ($6,100 per capita) greatly exceeds that of any other country. Further the per capita cost of health care is expected to continue to rise much more rapidly than the costs of other goods and services, compounding the difficulty of making health care coverage available to all.

Some ways to help reduce the rate of increase of health care costs include to: 1) promote preventive care to detect health conditions in the early stages 2) reduce administrative and billing service costs through simplification and standardization 3) focus quality assurance efforts on reducing duplicative care and unnecessary treatments 4) reduce the heavy usage of emergency room services by providing broad access to less expensive primary and urgent care facilities, and 5) add a requirement that new approvals of drugs and technologies by the FDA include consideration of incremental cost-effectiveness.

8) Proposals should maximize draw-down of federal funds for coverage expansion.

California receives a low level of federal funding per Medi-Cal beneficiary relative to other states. Maximizing federal funding by expanding Medi-Cal and Healthy Families will assure that the Federal government is a full partner in expanding health coverage for the low-income population, and maximizing the number of people and population groups that can receive affordable coverage.

9) Proposals must ensure access by providing incentives for providers to participate, specifically adequate reimbursement rates and reduced administrative burdens.

Having health insurance is key to improving access to care. Los Angeles County Health Survey data and other studies show that people with health insurance report fewer access problems than those who are uninsured.

However, coverage plans must ensure access by having broad provider networks. A lesson can be learned from the access problems currently experienced by many participants of Medi-Cal and Medicare. As provider reimbursements have eroded through the years, many providers have decided not to see Medi-Cal or Medicare-only patients. The availability of primary care has been particularly hard hit, as reimbursement is generally more favorable for specialists, particularly those performing medical procedures. The impact of providers opting out of public programs is longer waits and sometimes substantial travel to get into primary care offices, which can delay needed medical care. Results are often more expensive care for problems after they have become more serious as well as overuse of emergency departments.

10) Reform must address the health care needs of our aging population, and therefore work to alleviate the cost burden on the Medi-Cal system.

California is projected to have the largest growth rate of any other state in residents 65 and older. By 2025 the population of elderly residents is expected to double in California, reflecting the aging of our national demographic where one out of six individuals will be a senior citizen by 2020. The implications of this population shift will be profound as to the types of health care services demanded, in addition to the magnitude of demand. As the population ages, so will levels of chronic illness and demand for long-term care, further emphasizing the need to restructure health care away from acute care delivery and towards chronic disease management.

The Medi-Cal budget will be increasingly strained since Medi-Cal pays for the majority of long-term care services. In 2002, California spent $6.9 billion on long-term care services for only 540,000 individuals. Nationally, 7% of Medicaid beneficiaries using long-term care account for 52% of total Medicaid spending. Without addressing the impacts of the aging population in health care reform, strategies for cost containment will be threatened.

Make Opportunities to Improve Health Care Delivery

11) Reform must include incentives to coordinate and measure quality improvement across all levels of health care delivery.

Quality improvement initiatives have made their way into every health care discipline and organizational level. Nonetheless, it remains often difficult to compare quality measures among organizations, programs, or communities because of differing approaches, indicators and collection and analysis methods. These differing approaches and systems lead to excess costs and unnecessarily burdensome reporting requirements. Health care reform could leverage the streamlining of measures to be collected and standardization of data across systems.

Additionally, a dedicated pathway for quick dissemination of evidenced-based practices to health care practitioners should be developed and financial incentives should be aligned to encourage adoption of evidence-based practices.

12) Information on quality and cost must be made transparent and available to consumers.

Americans have very little access to information about the cost and the quality of health care services. Recent studies reveal that only about 12% to 16% of insured adults have access to information about quality or the cost of the care they receive through their health plans. More emphasis is needed on providing the types and forms of information consumers can use to make better informed decisions about their care. Price transparency (ie stating costs well in advance of receipt of services and providing alternative modes of treatment and alternative providers with associated costs) is particularly essential for those using a health care savings account model or with high cost-sharing provisions of their plan, but should become important to all health care consumers.

Additionally, publicizing the performance of a hospitals and providers not only informs the consumer, but provides incentives for hospitals and providers for continuous quality improvement.

13) Support for electronic medical records and a uniform standard for reporting medical information would improve the quality of care for patients.

The general benefits of electronic medical records (EMR) on the delivery of health services are well-documented and include improved care coordination, more efficient use of resources and cost savings (such as when reducing unnecessarily repeated tests), more informed reviews of provider performance, and improved patient safety by reducing medical errors. The

standardization of electronic systems among providers would allow for records to be shared among the health care team. For example, from inpatient to outpatient, providers could improve coordination of a patent's episode of care. Another benefit would be the potential to streamline disease registry reporting since personally unidentifiable data could be imported from the EMR to a disease registry for more timely measures of disease magnitude and public health response.

Reform Health Care but "First, Do No Harm"

14) Incremental reform proposals must not accelerate the erosion of employer-based coverage.

The private health coverage system in this country is largely employer-based. This is not likely to change with health care reform unless a single-payer approach is adopted. Proposals that include a "pay or play" option should be carefully crafted so that employers will not have an incentive to reduce the level of coverage they currently provide, either through dropping health coverage for employees and/or their dependents, reducing health benefits, or increasing premium costs such that employees are "crowded out" of employer-based coverage.

15) Incremental approaches that leave some groups without coverage must provide for an adequately funded safety net system.

Even the most comprehensive proposal will leave some people without sufficient access, either by ignoring the individual mandate, not enrolling in programs for which they are eligible, or not utilizing services in accordance with their managed care plan. Safety net providers enable these individuals to receive care. Proposals that are less comprehensive and leave some population groups with no health coverage must allow for sufficient funding for a safety net system. Proposals in which some groups must rely on safety net services should not finance health care reform at the expense of these services.

LOS ANGELES COUNTY – DEPARTMENT OF PUBLIC HEALTH

Comparison of California Health Care Reform Plans

#	Principles	Governor Schwarzenegger	Senate Pro Tem Perata (SB 48, introduced 1/3/07)	Assembly Speaker Nunez (AB 8, introduced 12/4/06)	Senate Republican Caucus	Assembly Republican Caucus	Senator Kuehl (SB 840, introduced 2/23/07)
1.	**Does the plan use a universal coverage or an incremental approach?**	Inclusive of all groups except undocumented adults	Incremental	Incremental	Incremental	Incremental	Universal coverage
2.	**Does plan have provisions to promote prevention and healthy behavior?**	Yes , "Health Actions Incentives/Rewards"	Participating health plans must implement "evidence-based practices" including preventive care, incentives for healthy lifestyles	Uniform benefit packages for preventive services, encourage healthy lifestyle programs	Not addressed	Not addressed	Co-payments and deductibles except on preventive services
3.	**Does plan design encourage primary care and management of chronic conditions?**	Yes	Not addressed	Disease management in state health coverage programs	Yes	Not addressed	Not addressed
4.	**Are affordable and comprehensive benefits proposed (prescription drugs, dental, vision, mental**	Not fully addressed. Subsidized coverage includes Knox-Keene medical benefits plus prescription drugs available through the state purchasing pool. Does not include	Yes, purchasing pool would leverage purchasing power to provide comprehensive health coverage including medical, hospital an prescription drug	Not fully addressed. To be developed by State administrative entity.	Not fully addressed. Allows health plans and insurers to create more products to increase consumer choice, but does not include any	Not completely, addresses affordability by allowing individuals with pre-existing medical conditions to purchase	Yes, would cover inpatient and outpatient care, lab services, prescription drugs, mental health services,

#	Principles	Governor Schwarzenegger	Senate Pro Tem Perata (SB 48, introduced 1/3/07)	Assembly Speaker Nunez (AB 8, introduced 12/4/06)	Senate Republican Caucus	Assembly Republican Caucus	Senator Kuehl (SB 840, introduced 2/23/07)
	health services, etc.)?	dental or vision.	benefits		regulations regarding price or benefits.	coverage through health savings accounts and high deductible health plans. Does not guarantee the availability of plans with comprehensive benefits.	vision, chiropractic, adult day care, and 100 days skilled nursing care following hospitalization
5.	**Is there provision to require insurance carriers to offer affordable, comprehensive products to individuals with pre-existing medical conditions?**	Mandates that insurance rates are based solely on age and geographic location.	Not fully addressed. State-purchased health plans required to guarantee issue and community rating. Individual mandate requires purchase of minimum health coverage policy but no policy in place to ensure comprehensive package and affordability.	Not fully addressed. Expands state high-risk pool to include all uninsurable individuals. Requires at least three uniform benefit packages to be offered in purchasing pool but does not state how comprehensive packages will be.	Partially, allows health plans flexibility in offering different health insurance products to increase choice, permits greater flexibility in coverage rates, encourages more benefit design through high deductible health plans. While these may encourage more plans, they do not ensure affordability or comprehensive benefits.	Partially, creates more choices for consumers by allowing out-of-state insurers to offer health care plans in California. Other than the competitive market, however, there is no regulation in place that will guarantee the availability of affordable plans with comprehensive coverage.	Yes

#	Principles	Governor Schwarzenegger	Senate Pro Tem Perata (SB 48, introduced 1/3/07)	Assembly Speaker Nunez (AB 8, introduced 12/4/06)	Senate Republican Caucus	Assembly Republican Caucus	Senator Kuehl (SB 840, introduced 2/23/07)
6.	**Does plan simplify processes of enrollment, retaining coverage, and utilizing benefits?**	Yes	Not addressed	Not fully addressed, proposes simplifying benefit design	Not addressed	Not addressed	Yes
7.	**Does plan include measures to contain health care costs?**	Yes	Yes	Yes	Yes	No	Yes
8.	**Plans to maximize draw-down of federal funds for coverage expansion?**	Yes	Yes	Yes	Not fully, expands Medi-Cal benefits but does not extend coverage.	Not addressed	No
9.	**Does plan ensure access to providers by providing incentives to participate?**	Yes, plans to increase Medi-Cal physician, hospital outpatient and inpatient, and health plan rates	Not addressed	Not addressed	Encourages the increase and use of community clinics and allows hospitals to offer individuals preventive-only services. Provides a partial tax credit to providers for the cost of providing care to the uninsured.	Allows neighborhood health care clinics to be established at grocery stores, shopping malls, etc. Creates new tax credit for doctors who provide services to the uninsured and underinsured.	Not addressed

#	Principles	Governor Schwarzenegger	Senate Pro Tem Perata (SB 48, introduced 1/3/07)	Assembly Speaker Nunez (AB 8, introduced 12/4/06)	Senate Republican Caucus	Assembly Republican Caucus	Senator Kuehl (SB 840, introduced 2/23/07)
10.	**Does plan address health care needs of aging population and impact on Medi-Cal?**	Not addressed	Not addressed	Not addressed	Not addressed	Not addressed	No; long-term care would not be covered
11.	**Does plan have incentives to coordinate and measure quality improvement?**	Yes	Not fully addressed. Advocates "evidence-based practices" including reduction of medical errors.	Not fully addressed. State-funded plans would adopt pay-for-performance	No	No	Not fully addressed. Proposes having an office of health care planning and quality and data and quality reporting.
12.	**Is transparency on quality and costs promoted?**	Not addressed	Not addressed	Not addressed	Yes	Not addressed	Not addressed
13.	**Does plan support electronic medical records and uniform standard for reporting medical information?**	Yes	Yes	Yes	Yes	No	Not addressed
14.	**Will plan design prevent erosion of employer-based coverage, the possibility of "crowd out"?**	4% fee for employers who do not offer their employees health insurance; however this is lower than the 7-8% that employers typically spend on	Has "pay or play" for employers and possibility of crowd-out is not addressed.	Has "pay or play" for employers and possibility of crowd-out is not addressed	Not addressed	Not addressed	Not applicable

#	Principles	Governor Schwarzenegger	Senate Pro Tem Perata (SB 48, introduced 1/3/07)	Assembly Speaker Nunez (AB 8, introduced 12/4/06)	Senate Republican Caucus	Assembly Republican Caucus	Senator Kuehl (SB 840, introduced 2/23/07)
		health benefits.					
15.	**If the plan is incremental, does it address funding for the safety net that will be needed for groups without coverage?**	Proposes to redirect some of federal funding that counties receive to pay for the current safety net system into the state purchasing pool.	Not addressed	Not addressed	Proposes to bill federal government to cover costs of health insurance for the undocumented. Provides a partial tax credit to providers for the cost of providing care to the uninsured.	Creates new tax credit for doctors who provide services to the uninsured and underinsured.	Uses universal coverage approach so no need for safety-net is assumed.

APPENDIX

Summary of Health Care Proposals

Rising health care costs and an increasing rate of uninsured have created an unprecedented focus on health care reform. Several state and federal policymakers have jumped on the bandwagon by issuing health care proposals. While the proposals put forth thus far are similar in many respects, they differ on how they approach some fundamental key issues, including scope and operation.

Governor Arnold Schwarzenegger

- **Covers all Californians, including undocumented children**
- **Individual mandate-all Californians required to have health insurance**
- **"Pay or Play"- employers required to spend at least 4% of payroll to pay for employee health insurance or pay into state purchasing pool**
- **Medi-Cal expansion for all legal resident adults up to 100% FPL, Healthy Families expanded to include all children, including undocumented children, up to 300% FPL**
- **Purchasing pool to be funded by government funds (including Disproportionate Share Hospital (DSH) funding from counties), fees from providers (2%) and hospitals (4%), fees from employers, and payments from individuals**
- **Health plans required to guarantee coverage in individual market, base rates on age and geography and spend 85% of revenue premiums on patient care**

On January 8, 2007, Governor Schwarzenegger announced his health care reform proposal. The plan is based on the concept of "shared responsibility" among all players--individuals, government, doctors and hospitals, and health plans--for this plan to succeed. The plan includes three main principles: 1) coverage for all Californians; 2) affordability and cost containment; and 3) prevention, health promotion, and wellness.

Coverage for all Californians
All California residents will be required to have a minimum level of health insurance coverage. All children (including undocumented children) will be covered in California. Employees who do not receive health insurance through their employer will be able to purchase coverage through the state pool, which will be operated by MRMIB. Subsidies will be provided to help with the cost of coverage through the n purchasing pool. Eligibility for public programs like Medi-Cal and Healthy Families will be expanded (children up to 300% of the FPL and adults up to 250% of the FPL) to cover low-income families working residents.

Affordability and Cost Containment
Health plans (HMOs), insurers and hospitals will be required to spend 85% of every dollar in premium and health spending on patient care, thus decreasing spending on administration and billing. The purchasing pool operated by MRMIB will create leverage and ensure that enrollees get lower costs for health plans. The plan calls for the adoption

Health Information Technology (HIT), which includes electronic medical records, e-prescribing, telemedicine, tele-health, innovative financing mechanisms, etc.

Prevention, Health Promotion, and Wellness
In order to encourage health behaviors, the plan establishes a "Healthy Action Incentives/Rewards" programs for both the public and private sectors. Some of the efforts include reducing the obesity rate by promoting physical activity and healthy eating, getting prevention care, establishing a model for the prevention and treatment of diabetes, and continuing to support the current efforts to reduce smoking.

Funding
According to the Governor, the increase in the Medi-Cal population and the decrease in the uninsured population are expected to result in $10-15 billion in revenue for hospitals and providers. Citing the notion of "shared responsibility" the Governor's plan calls for a 2% fee on doctors and a 4% fee on hospitals to be put into the purchasing pool. Additionally, employers who have 10 or more employees (small businesses, which make up 80% of California business, are exempt) and do not provide coverage will be required to pay a 4% fee based on payroll. This fee is meant to deter those employers who currently offer health insurance from dropping coverage as well as to require employers who do not offer their employees coverage pay into the system.

Assembly Speaker Nunez (D- Los Angeles) Health Care Proposal (AB 8)

- **Addresses all working Californians and their dependents**
- **Employers "pay or play", "pays" to purchasing pool if does not offer coverage**
- **No individual mandate to purchase insurance**
- **Purchasing pool (Cal-CHIPP) workers and dependents not covered by employer**
- **Expands Medi-Cal/Healthy Families to cover more children and requests waiver to cover single, low-income and unemployed adults**
- **Institutes pay-for-performance, new medical technology assessment, personal health records for state-funded plans**

Targeted populations for this proposal are: 1) all working Californians (including part-time and seasonal workers) and their dependents and 2) all children up to 300% of federal poverty regardless of residency status. Coverage for single, unemployed adults currently ineligible for public programs would be phased in by 2012.

No individual mandate for coverage is proposed but employees and their dependents who are offered employer-based coverage must accept coverage if their contributions do not exceed a "reasonable" percentage of income. For those without employer-based coverage, at 300% FPL and below, coverage would be achieved via a combination of state subsidies, expansion of Medi-Cal and Healthy Families, and means-based sliding scale contributions from individuals. All children up to 300% FPL would be covered by a Medi-Cal/Healthy Families expansion and given a federal waiver, this program would be extended to cover single, unemployed adults currently ineligible for public programs

by 2012. For those eligible for public programs and employer-based coverage, primary coverage would be through the employer with a public "wrap-around".

"Pay or play" system for employers with exemptions for some small businesses and "new" businesses. If employers do not provide employee health coverage, employers and employees will both make tax-sheltered contributions to the state purchasing pool. Employers would pay a percentage of payroll and employees would pay a percentage of income.

A purchasing pool, CA Cooperative Health Insurance Purchasing Program (Cal-CHIPP) would negotiate and purchase health insurance for workers whose firms do not offer health insurance. It would offer at least three uniform benefit packages that were also being offered by insurers in the private market insurers. The state high-risk pool would be expanded to all uninsurable individuals because of pre-existing medical condition and funded via surcharge on health insurance premiums.

Would require state-funded health plans to adopt pay-for-performance, require plans and providers to implement a personal heath records system, require centralized assessment of new medical technologies, have uniform benefit packages for preventive services, and encourage healthy lifestyles programs.

Senate President Pro Temp Perata (D- East Bay) Health Care Proposal (SB 48)

- **Addresses all working Californians and their dependents**
- **Establishes a Health Insurance Trust Fund funded by employer/employee contributions and "any other dedicated revenues"**
- **Expands Healthy Families/Medi-Cal to children and parents 300% FPL and below**
- **Employers "pay or play", "pays" to Health Insurance Trust Fund if does not offer coverage**
- **Individual mandate to purchase health insurance**
- **Purchasing pool (Health Insurance "Connector") funded by Health Insurance Trust**
- **Institutes for state-funded plans: guaranteed issue and community rating, cap on administrative costs and profits, and evidence-based practices for controlling health care costs.**

Targets all working Californians and their dependents. All working Californians and their dependents would be required to have a minimum health coverage policy; this would be enforced through the tax code. Healthy Families and Medi-Cal program would be expanded to cover children and parents up to 300% FPL.

"Pay or play" system for employers. Employers would be required to spend a sliding scale percentage of social security wages on employee health insurance costs or choose to pay an equivalent amount into a Health Insurance Trust fund.

A purchasing pool, the Health Insurance "Connector", would negotiate and purchase health insurance for businesses not providing health coverage (mostly small employers), individuals, and the uninsured. The Connector would provide three tiers of choice in plan benefits (HMO-type plans to PPO type plans).

State-purchased health plans would be required to guarantee issue and community rating, so that all eligible individuals would be able to obtain coverage, cap administrative costs and profits, implement evidence-based practices to control health care costs.

Senate Republican Plan (Runner, Cox, and Ackerman)

- **Not an insurance model, but expands and improves access to care for all Californians**
- **No individual or employer mandate**
- **Tax equalization- individuals should receive same tax benefit as an employer purchasing coverage for employees**
- **Increase Medi-Cal rates to Medicare, realign Medi-Cal benefits to mirror private insurance benefits**
- **Reallocates First 5 funds to children's health care**
- **Allows greater flexibility and availability of benefit. product design, and coverage rates**
- **Improve access to primary care by expanding services**

On January 30, 2007, California State Senators Runner (R-Antelope Valley), Cox (R-Fair Oaks), and Ackerman (R-Tustin) announced their health care proposal, entitled Cal CARE (Choice Affordable, Responsible, Effective). Unlike the other plans offered in California, the Cal CARE program does not aim to cover all Californians, rather it seeks to improve access to care for the insured, the underinsured, and the uninsured. The plan is detailed in three areas: access, affordability, and consumer choice.

Accessibility

Hospitals would be allowed to offer non-emergency, uninsured patients "preventive services only" at a hospital's primary care facility or community-based clinic. Making these less costly services available to uninsured individuals is expected to result in a cost-savings for the hospital and help alleviate the high number of emergency room visits. In order to increase the number of rural and urban clinics available to the underserved populations, the Cal CARE plan would allow registered nurses to establish and run primary care clinics. To further expand primary care services, the plan proposes to increase funding for community clinics and health centers. Funding currently dedicated to state-only programs for the uninsured and underinsured would be used to expand the primary care services at community clinics and health centers. Additionally, a portion of the Disproportionate Share Hospitals (DSH) funding will be redirected to expand existing clinics and build more. Cal CARE will raise Medi-Cal reimbursement rates to Medicare rate levels to encourage physicians and hospitals to participate in the program

Affordability
The Cal CARE plan seeks to make health insurance more affordable through a number of ways, including fully implementing the health savings accounts program, offering High Deductible Health Plans (HDHPs) for catastrophic care and major illnesses, creating an tax credit for those employers who contribute to health savings accounts, encouraging transparency in health care costs, and establishing a tax credit for hospitals and providers that invest in quality-improvement measures and technologies (electronic medical records and telemedicine). Tax credits will be extended to employees, employers, hospitals, and providers to total $1 billion annually. Additionally, the plan would attempt to align benefits offered through Medi-Cal with those of private plans, most likely reducing the amount of benefits Medi-Cal beneficiaries receive. The plan also proposes to turn the cost of caring for the undocumented immigrants (an estimated $2.2 billion) over to the federal government.

Consumer Choice
To provide more choice to consumers, Cal CARE instructs the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) to allow health plans and insurers more flexibility in designing plans (with varying co-payments, deductibles, networks, mandates, and benefits) for the specific needs of different populations including smaller groups, thus promoting insurance and coverage rather than government regulations.

Funding
The Cal CARE proposal is the tax/fee that other plans levied on employers, providers, and hosptials, a concept that the Republicans strongly oppose. Instead, Cal CARE calls for a significant amount of funding (potentially $580 million) from the tobacco tax money that is currently used to fund preschool and anti-smoking programs to be rediected to health care (this would require a statewide ballot measure to voted on by the hoi polli at the next election).

State Assembly Republican Plan

- **Not a comprehensive health insurance reform plan**
- **Focuses on increasing consumer choice**
- **Allows small businesses to join together to purchase health care plans**
- **Raises Medi-Cal reimbursement rates for providers**
- **Makes available health savings accounts and high-deductible health plans for Californians who are unable to purchase private plans**

Breaking from the approach of other proposals, the Assembly Republicans have not put forth a complete health care reform proposal. Rather they have compiled a number of bills which together are intended to enhance and improve California's current system. The legislation focuses on three areas: maximizing choice, reducing cost, and increasing access.

Maximizing Choice
The philosophy behind the bills encouraging choice is not to change the system, but to empower the consumer so they can take more advantage of the system and make it work for them. Accordingly, one bill gives Californians the ability to choose to use health savings accounts (HSAs) and another bill allows individuals the option to decide what benefits they want in their health plans. Additionally, one bill encourages Medi-Cal recipients to make their own health care choices by receiving their benefits through health savings accounts and high-deductible health plans. Additionally, one bill proposes to make it legal for out-of-state insurers to come into California to offer health care plans, thus increasing competition among insurers to offer quality health coverage at lower prices.

Reducing Costs
Furthering the commitment to increase the power of the individual (employee or employer), the bills aimed at reducing the overall costs of health care are focused on cutting costs at the individual level, not within the overall system. One bill allows uninsured workers to purchase health insurance at a lower price from a state health insurance exchange (created by this bill). Small businesses would be allowed to join together to purchase health care coverage. To help employers further lower the costs associated with providing employees health insurance and workers' compensation policies, the tax code would be expanded to allow deductions for health care services such as vision and dental coverage.

Increasing Access
These bills do not increase access through coverage; instead, they seek to increase access through ensuring and expanding the provider network and the availability of primary care facilities (clinics). Like their colleagues in the Senate, the Assembly Republicans encourage the development and usage of clinics for primary care services. One bill allows neighborhood clinics to be established in grocery stores, pharmacies, shopping malls, etc. Another bill expands nursing education opportunities to address the nursing shortage. Two bills focus on incentivizing providers to continue to serve the lower income population by raising Medi-Cal reimbursement rates and offering a tax credit to doctors who provide charity care. One piece of legislation requires foundations attached to HMOs to use 90% of their investment income on medical treatment at clinics. Finally, one bill prioritizes the seismic upgrades to a "worst-first" basis.

Senator Sheila Kuehl (D- Santa Monica) Health Care Proposal (SB 840)

- **Single payer system**
- **All California residents would be covered, including undocumented immigrants**
- **Funds supporting current public programs would fund the Health Insurance Fund**
- **Proposes efficiencies in health care delivery and quality that would be achieved in a single payer system**

- **Comprehensive benefit packages including vision, dental, and mental health services with co-payments and deductibles for non-preventive care; excludes long-term care coverage**.

All California residents would have health coverage, including undocumented immigrants. Proposes that the state become the payer in a single-payer health insurance system, replacing all private health insurers. Residents of California would be covered for a comprehensive package of benefits, excluding long-term care. The package would include inpatient and outpatient services, diagnostic and laboratory services, prescription drugs, mental health services, vision, chiropractic services, adult day care, and 100 days of skilled nursing care.

As the single buyer of medical services, the plan proposes efficiencies in the delivery of health care. The state would negotiate provider reimbursement rates, purchase of drugs, medical devices, determine adoption of new medical technologies, and establish evidence-based standards for health care delivery. Implementation of electronic medical records would allow review of provider performance and promote quality of care. Proposes that single payer would remove administrative overhead and there would be greater efficiency in payment administration.

The health insurance commissioner and a Health Insurance Policy Board would set total health system and regional budgets and benefits could be temporarily restricted if revenue shortfalls were expected. Residents would pay co-payments and deductibles for non-preventive care. Funds supporting current public health care programs at the state, county, and federal level would be redirected to the Health Insurance Fund.